SUPPORT FOR THE PAIN RELIEF PROMOTION ACT

HON. JAMES A. BARCIA

OF MICHIGAN

IN THE HOUSE OF REPRESENTATIVES

Monday, October 25, 1999

Mr. BARCIA. Mr. Speaker, my esteemed colleague from Oregon, Mr. BLUMENAUER, recently presented remarks on the floor to defend Oregon's assisted suicide policy and to criticize the proposed Pain Relief Promotion Act, H.R. 2260.

First of all, I think it is important to clarify the fact that H.R. 2260, the Pain Relief Promotion Act, does not limit states' ability to legislate assisted suicide. It simply clarifies that assisted suicide may not take place with federally controlled substances. This allows states to pass their own laws while clarifying the boundaries of federal involvement regarding assisted suicide. This bill also does not establish any new authority to penalize assisted suicide. My colleague has every right to speak in favor of the policy his constituents have chosen. But by the same token, representatives of the other 49 states that have chosen not to follow such a policy have a right to ask: Why should we be voiceless participants in Oregon's experiment with assisted suicide?

Mr. BLUMENAUER has expressed grave concern over the provision in the bill that makes it illegal to intentionally prescribe federally controlled drugs with the intent to cause a patient's death. Under this provision, he says, law enforcement personnel will be judging, for the first time, whether a doctor's ''intent'' is to cause a patient's death. I would like to take the time right now to respond to this objection.

Currently, the Drug Enforcement Administration (DEA) routinely makes these judgments. They have always had the right to revoke controlled substance permits based on abuse by health care workers. Whenever a prescription is written for a federally controlled substance, a DEA prescription is printed using a federal DEA registration number which is then attached to the actual bottle of pills. In this way, the DEA can keep record of and check whether or not federally controlled drugs are being used for ''legitimate medical purposes.'' There are numerous instances in which physicians have had their DEA registrations suspended or revoked because they used these drugs in ways that led to patients' deaths by drug overdose. Clearly then, the DEA has the authority, right and experience to do what it has always been doing—monitor the use of federally controlled substances. Even more extensive federal involvement, though, has been prompted by Oregon's assisted suicide law. It is my colleague's own state legislature, in fact, that has escalated federal involvement by enacting a law that freely uses federally controlled substances for assisted suicides. In so doing, Oregon has practically demanded, perhaps unintentionally, that the federal government review and clarify its policy regarding what constitutes a ''legitimate medical purpose.'' The federal government obviously has a right to say how federally controlled substances can be used. And so it is the aim of H.R. 2260 to address this question by clarifying the federal government's policy on the use of federally controlled substances in relation to assisted suicides.

Department of Justice policy currently forces the federal government to implicitly endorse assisted suicide by directing the DEA to allow federally controlled substances to be used in any manner which a state's assisted suicide law may prescribe. Every time a lethal overdose of barbiturates is prescribed to assist an Oregon citizen's suicide, the federal authority of the DEA is invoked to authorize the prescription. Since the Controlled Substances Act requires that such prescriptions be used for a ''legitimate medical purpose,'' the federal government implicitly endorses the use of federally controlled substances in each case of assisted suicide as a ''legitimate medical purpose'' under current Justice Department Policy. It is only appropriate then, that we clarify how federally controlled substances can be used instead of letting an individual state that is heroically experimenting with democracy dictate how these federally controlled substances will be used. After all, they are federally controlled substances and they require federal control.

H.R. 2260 clarifies that assisted suicide will not be performed with the federal government's blessing. It also ensures that enforcement of the Controlled Substances Act will distinguish between intentional killing and the unintended hastening of death that may rarely occur as a side-effect of aggressive pain control. (This particular distinction, by the way, is found explicitly in almost all state laws against assisted suicide enacted in recent years; it was upheld as a reasonable and workable legal standard by the U.S. Supreme Court in its Vacco v. Quill decision two years ago.) Finally, H.R. 2260 provides the funds needed to begin to seriously advance our understanding of pain management.

Beginning with the premise that aggressive pain control is to be encouraged as a legitimate part of modern medical practice, the legislation backs up this declaration through $5 million per year for the training of health professionals in palliative care, and for the education of law enforcement personnel so that they will be sensitive to the legitimate needs of modern pain management when they perform their necessary task of preventing misuse. Because this legislation sends such a clear and positive message about pain management to physicians and patients, it has been endorsed by organizations that both deal with pain issues on a regular basis and are in a position to judge the merits of the legislation. Among a notable list of supporters are the American Medical Association, the National Hospice Organization, the Hospice Association of America and the American Academy of Pain Management.

In the end, the federal government, in concert with groups that understand and are active practitioners of pain management, must make a policy decision regarding the appropriate use of drugs that fall within its jurisdiction. Will they be used to kill pain or kill patients? I believe H.R. 2260 makes the right choice.

NATIONAL CHILDHOOD LEAD POISONING PREVENTION WEEK

HON. CARRIE P. MEEK

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Monday, October 25, 1999

Mrs. MEEK of Florida. Mr. Speaker, last week the Senate passed, by unanimous consent, a resolution which designates this week—October 24, 1999, through October 30, 1999—and a similar week next year as ''National Childhood Lead Poisoning Prevention Week.'' I would like to take this opportunity to inform my colleagues about the very serious problem of childhood lead poisoning.

Lead poisoning is a leading environmental health hazard to children in the United States. According to the United States Center for Disease Control and Prevention, 890,000 preschool children in the United States have harmful levels of lead in their blood which can cause serious, long-term harm to children, including reduced intelligence and attention span, behavior problems, learning disabilities, and impaired growth. Children from low-income families are 8 times more likely to be poisoned by lead than those from high income families.

Mr. Speaker, I have worked with the Alliance to End Childhood Lead Poisoning and other concerned groups to help address this problem. I would like to submit the following article from the American Journal of Public Health which further details the lead poisoning problem and strategies to combat it.

[From the American Journal of Public Health, June 1999]

PROTECTING CHILDREN FROM LEAD POISONING AND BUILDING HEALTHY COMMUNITIES

Lead's toxicity to human organs and systems has been extensively documented for over 2 millennia. The 20th century is remarkable for the dispersal of lead throughout the human environment, making lead poisoning a community health problem of global dimensions.[1] Young children are at highest risk because of lead's neurotoxic effects, which reduce intelligence and attention span and cause learning difficulties and behavior problems.[2,3] Blood lead screening and surveillance are important tools, but primary prevention requires controlling sources of exposure. Although the challenge varies from country to country, the steps needed to eliminate this disease are now apparent.

EVIDENCE THAT ENVIRONMENTAL CONTROLS WORK

Over the past quarter century, progress on childhood lead poisoning in the United States has been remarkable: the mean blood lead level of US children fell by 80%, and the number of children with elevated blood leads declined by 90%.[4,5] These changes did not occur spontaneously or by chance. Strict regulation of many lead uses, enacted after decades of determined industry opposition, has gradually detoxified the air, water, and food supply. The evidence is clear that controlling ongoing sources of lead exposure produces immediate and significant health benefits, which typically far outweigh the costs.[6] The difficulty of cleaning up once lead contaminates the environment underscores the urgency of controlling it at the source.

THE LEGACY OF LEAD-BASED PAINT

Despite impressive progress, lead poisoning remains a serious environmental health hazard in the United States: 4.4% of all children aged 1 to 5 years have elevated blood lead levels (≥10 μg/dL).[5] Lead-based paint in nearly two thirds of all U.S. housing poses by far the greatest remaining challenge.[7] (In particular communities and populations, a variety of other sources and pathways also expose children to lead.) While children can be severely poisoned by eating paint chips, the principal pathway is chronic exposure to settled lead dust, which gets on children's